HOME VENTILATOR DISCHARGE PLANNING CHECKLIST

It is the expectation of the CCS Program that the Special Care Center or Discharging Facility will complete the following steps in an effort to ensure a safe home environment for the ventilated child.

Client's name: _____
Client's DOB: _____ Client's CCS number: _____
Discharging Facility: _____
Home Ventilation Clinic or Pulmonary Special Care Center for outpatient services:
_____

- O Home Ventilation Clinic or Pulmonary Special Care Center clinic visit arranged for no more than 2 weeks following an inpatient stay.
  Appointment date: _____
- O Home Ventilation Clinic or Pulmonary Special Care Center Outpatient clinic visit arranged for every 3-4 months.
- O Home caregiver around the clock. Describe arrangements: _____
  _____
- O Reasonable respite and emergency caregiver coverage
- O Training of all caregivers on the use of the actual ventilator the client will use in the home.
- O Current basic CPR training of all caregivers.
- O Caregivers have demonstrated ability to provide mechanical respiratory support for the client when necessary.
- O The DME vendor's licensed respiratory care practitioner, who will provide the in-home service of the client's ventilator, has met the child and family and has participated in the family training in the inpatient setting.

Check one of the following bullet points:

- O In-home shift nursing care is required at the following level (hours per day, licensure of the nurse): _____
- O In-home shift nursing care is not required, or is not available and safe alternative caregivers have been identified. Please describe: _____
  _____

Person Completing Form: _____
Physician Signature: _____

Requirements based on PEDIATRIC HOME VENTILATORS: DISCHARGE PLANNING AND AFTER DISCHARGE MANAGEMENT GUIDELINES

HOME VENTILATOR REAUTHORIZATION CHECKLIST

Requests for reauthorization of ventilators are required every 12 months.

Client's name: _____

Client's DOB: _____ Client's CCS number: _____

Date: _____

Home Ventilation Clinic or Pulmonary Special Care Center for outpatient services:
_____

Date of Clinic Evaluation (must be within the previous 4 months): _____

- What is the client's diagnosis and the rationale for mechanical ventilatory support?
  _____
  _____
  _____

- Does the client have a potentially reversible condition?(circle one) Yes / No

- If yes, describe the plan for weaning ventilatory support.
  _____
  _____

- Current Ventilator settings: _____
  _____

- Type of ventilator requested. (circle one) Volume Limited / Pressure Limited

- Ventilator Model Requested: _____

Person Completing Form: _____

Physician Signature: _____

Portable Ventilators with invasive interface (intubation or tracheostomy)						
Brand Name	**LTV 950**	**LTV 900**	**Newport HT50**	**LTV-800**	**LP-10**	**PLV-100**
Manufacturer	Pulmonetic Systems, Inc	Pulmonetic Systems, Inc	Newport Medical Instruments	Pulmonetic Systems, Inc	Mallinckrodt	Respironics
Website	http://www.pulmonetic.com	http://www.pulmonetic.com	http://www.newportnmi.com	http://www.pulmonetic.com	http://www.puritanbennett.com	http://plv100.respironics.com
HCPCS Code	E0463	E0463	E0463	E0450	E0450	E0450
Monthly Rental	$1,150	$1,150	$1,150	$650	$650	$650
Dimensions (H x W x D)	3 in x 10 in x 12 in	3 in x 10 in x 12 in	10.24 in x 10.63 in x 7.87 in	3 in x 10 in x 12 in	9.75 in x 14.5 in x 13.25 in	9 in x 12.25 in x 12.25 in
Weight	13.4 lbs	13.4 lbs	15 lbs	12.85 lbs	35 lbs	28.2 lbs
Portability	maximum	maximum	maximum	maximum	limited	limited
Volume Limited Machine Breaths	**Yes Control, Assist/Control, SIMV**	Yes Control, Assist/Control, SIMV	Yes Assist/Control, SIMV	Yes Control, Assist/Control, SIMV	Yes Assist/Control, SIMV	Yes Control, Assist/Control, SIMV
Presure Limited Machine Breaths	Yes Control, Assist/Control, SIMV	No	Yes Assist/Control, SIMV	No	Yes Pressure Limited (fixed flow)	No
Pressure Support for Spontaneous Breaths	Yes adjustable rise time and flow termination	Yes adjustable rise time and flow termination	Yes	No	No	No
Adjustable Trigger Sensitivity	Yes "Flow"	Yes "Flow"	Yes "Pressure"	Yes "Pressure"	Yes "Pressure"	Yes "Pressure" (limited control)
PEEP	Yes	Yes	Yes	Yes	No	No
CPAP	Yes	Yes	Yes	add on system NOT FDA approved	add on system NOT FDA approved	add on system NOT FDA approved
Age Range	Pediatric - Adult	Pediatric - Adult	Pediatric - Adult	Pediatric - Adult	Pediatric - Adult	Pediatric - Adult
Patients under 10 Kg	**	**	No	*	No	*
Patients with large air leaks around tracheostomy	**	**	**	*	*	*
Patients with intermittenly high airway pressures	**	**	**	*	*	*
Patients with weak respiratory muscles	**	**	**	*	*	*
Patients with no spontaneous respirations	*	*	*	**	**	**
	* = good ** = better					

REFERENCES

Textbook of Pediatric Intensive Care Mark C Rogers ed., 3rd Edition

Hall, J and Wood, L Liberation of the Patient From Mechanical Ventilation. JAMA 3/27/87 p 1621-1628

Tobin MJ, Current Concepts: Mechanical Ventilation N Engl J Med 1994;330:1056-1061

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